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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BINU BESSY MATHEW** **aka BINU ANI OOMMEN** **13843 Camino Canada, Unit 24** **El Cajon, CA 92021** **Registered Nurse License No. 709634** Respondent.	Case No. 2013-255 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 7, 2007, the Board of Registered Nursing issued Registered Nurse License Number 709634 to Binu Bessy Mathew, also known as Binu Ani Oommen (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2013, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

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8. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUG

10. Hydromorphone, also known by the brand name Dilaudid, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(J) and is a dangerous drug pursuant to Business and Professions Code section 4022.

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FACTS

11. On or about November 5, 2010, the Board received information from the California Department of Public Health (DPH) that Respondent was among five licensed registered nurses, all employed at Sharp Grossmont Hospital (Sharp) in San Diego, who failed to adhere to the hospital's written policy and procedure in that they all failed to ensure the right medication dose was administered to a patient pursuant to the physician's orders. As a result of the complaint, the Division of Investigation (DOI) conducted an investigation into the allegations.

12. Respondent was hired by Sharp on August 27, 2007. As part of her initial and ongoing training, Respondent was responsible for complying with Sharp's Policy and Procedure No. 43109.99 entitled "*Pyxis/Pyxis Profile Automated Medstation Use: Medications.*" The purpose of the policy and procedure was to establish best practices for the appropriate utilization of Pyxis Medstations[1] and adjunct products such as medication storage, dispensing and charging systems for approved controlled substances, floor stock, and formulary medication, and to establish routine quality assurance for its use.

13. Respondent was also responsible for complying with Sharp's Policy and Procedure No. 30035.99 entitled "*Medication Administration.*" The purpose of the policy and procedure was to provide guidelines for the safe and accurate administration of medications to patients and proper documentation in the medical record. This policy and procedure contained a Red Rule, which is a critical behavior in a policy or procedure that is essential to safety. Specifically, in administering medications, the Red Rule required that staff adhere to the "6 Rights" (right patient, right drug, right dose, right route, right time, and right rationale). The nursing staff was required

[1] "Pyxis" is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, the date and time the medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code. In some instances, a biometric scanner utilizes a user's thumbprint to access the control panel. Sometimes only portions of the withdrawn medications are administered to the patient. The portions not administered are referred to as "wastage." Wasted medications must be disposed of in accordance with hospital rules and must be witnessed by another authorized user and recorded in Pyxis.

to maintain patients' medication history in Cerner, an electronic medication administration record system used by Sharp.[2]

14. On the morning of October 15, 2010, a 59-year-old female (hereinafter referred to as Patient 309), presented to the Sharp emergency room complaining of a headache and abdominal pain that radiated to her back. Patient 309 was diagnosed with acute pacreatitis and was admitted as an inpatient at approximately 16:19 hours. At 17:37, the attending physician ordered 0.5 mg hydromorphone every two hours as needed for moderate pain, for a total of four doses. However, the physician entered an order to discontinue the hydromorphone at 18:12. The orders were reviewed and verified by an LVN and a pharmacist.

15. At 18:16 hours, the physician ordered hydromorphone (in a 1 mg. syringe) to be administered intravenously every three hours as needed: 0.4 mg for mild pain, 0.6 mg for moderate pain, and 0.8 mg for severe pain.

16. Patient 309 was subsequently transferred to Sharp's Nursing Unit (2 East) just after midnight, and was assigned to the care of Nurse Rosario. The 2 East admitting physician continued the order for hydromorphone with the same dosing parameters (0.4 mg for mild pain, 0.6 mg for moderate pain, and 0.8 mg for severe pain).

17. At approximately 02:50 on October 16, 2012, Nurse Rosario went to Cerner to access Patient 309's eMAR. When Nurse Rosario opened Patient 309's eMAR, she later reported that she saw text for the physician's orders clumped together and it was hard to read. Nurse Rosario believed she saw an order for 4 mg hydromorphone. When Nurse Rosario attempted to withdraw 4 mg. of hydromorphone from Pyxis, a dose alert ("speed bump") appeared. Nurse Rosario requested that Respondent act as a witness to the removal of the 4 mg. hydromorphone from Pyxis. When Respondent approached the Pyxis, she saw the witness verification screen.

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[2] An Electronic Medication Administration Record (eMAR) is a point-of-care process that utilizes barcode reading technology to monitor the bedside administration of medications. When a nurse uses this technology, medication orders appear electronically in a patient's chart after pharmacist approval. The technology also alerts nurses electronically if a patient's medication is overdue. Before administering medication, a nurse is required to scan the bar codes on the patient's wristband and then those on the medication itself. If the two do not match the approved medication order, or if it is not time for the patient's next dose, a warning is issued.

Respondent placed her finger on the biometric scanner to release the medication. Pyxis asked Nurse Rosario if she wanted to withdraw 4 mg. of hydromorphone, and Nurse Rosario selected "yes." The Pyxis drawer opened and Respondent saw a 4 mg. hydrocodone carpuject. Nurse Rosario removed the 4 mg. carpuject and Respondent left the room. Respondent never reviewed the physician's order and did not question the "speed bump" dose alert.

18. Respondent reported that standard protocol for witnessing a medication withdrawal is to ask the nurse if she looked at the physician's order, and that she also looks at it herself. Respondent admitted to investigators that she did not follow Sharp policy and review the physician's order prior to witnessing a medication withdrawal.

19. At 04:09 hours, Patient 309 was found unresponsive, in asystole ("flatline"). Respondent assisted with CPR until the Code Blue Team arrived. Patient 309 was resuscitated, but she had experienced anoxic brain injury and remained unresponsive. Life support was withdrawn on October 18, 2010, and she died that afternoon.

20. The Deputy Medical Examiner for San Diego County listed Patient 309's cause of death as arteriosclerotic cardiovascular disease and the manner of death as "natural."

21. The Department for Health and Human Services conducted a review of the incident and prepared a summary statement of deficiencies. The report found that the nurses involved in the care of Patient 309 failed to follow written policy and procedure related to medication administration, failed to ensure that medications were administered in accordance with the orders of the practitioner responsible for the patient's care, and failed to ensure that the medication administration record accurately reflected the medication administration time. The report stated that "The four RN's from 2 East failed to adhere to the hospital's written policy and procedure titled Medication Administration (#30035.99). Specifically [RN Rosario], [Respondent], [RN Robert], and [RN Judith] all failed to ensure that the right dose was administered to Patient 309 as it was prescribed, and when presented an opportunity to stop the medication error failed to verify the correct dose."

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CAUSE FOR DISCIPLINE

(Incompetence)

22. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that she was incompetent, as defined by California Code of Regulations, title 16, section 1442, in that on or about October 16, 2010, while employed by Sharp, as detailed in paragraphs 11-21, above, Respondent failed to follow written policies and procedures related to medication administration, and failed to ensure that medications were administered in accordance with physician's orders. Respondent failed to comply with the hospital's Red Rule which required she adhere to the "6 Rights" (right patient, right drug, right dose, right route, right time, and right rationale). Respondent failed to ensure that the right dose was administered to Patient 309 as it was prescribed, and when presented an opportunity to stop the medication error, she failed to verify the correct dose. Respondent failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 709634, issued to Binu Bessy Mathew, also known as Binu Ani Oommen;

2. Ordering Binu Bessy Mathew to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: October 10, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2012703875